TEXAS
Health and Human
Services Commission

Date

Eligibility Specialist
Office Address and Telephone No.

(Name and Address of Insurance Company)

This individual is being considered for assistance. The requested Long-Term Care Partnership information will assist HHSC in arriving at a determination. A signed authorization to release information is enclosed.

Name of Insured/Individual's No.	Policy No.

Comments:

Area Code and Telephone No.

Signature–Eligibility Specialist _____ Date _____

Please confirm the status of the above referenced policy:		
Owner	Insured	
Date of Issue	State of Issue	
Qualified Partnership Policy ☐ Yes ☐ No	Terminated ☐ Yes Date:	Exhausted ☐ Yes Date: ☐ No
Lifetime Benefit Value	Benefits Paid to Date	

If the Long-Term Care Partnership policy is continuing to pay benefits, please complete the following:		
Premium Amount	When Paid ☐ Monthly ☐ Quarterly ☐ Yearly	
Begin Date	End Date (if lapsed)	
Type Coverage:	Prescription Drug Coverage? ☐ Yes ☐ No	
Medicare Skilled Facility? ☐ Yes ☐ No	Other Nursing Home Coverage? ☐ Yes ☐ No	Assignable to Providers? ☐ Yes ☐ No
Address for Claims:		

Area Code and Telephone No.

Signature–Insurance Company Representative _____ Date _____